



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL AT RENAISSANCE
101 PASEO DEL PRADO
EDINBURG TX 78539

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

LM INSURANCE CORP

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-10-2936-01

MFDR Date Received

FEBRUARY 19, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The Requestor did not submit a position summary with their submission to Medical Fee Dispute Resolution.

Amount in Dispute: \$6,681.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that Doctors Hospital at Renaissance has been appropriately reimbursed for services rendered to [injured worker] for the 06/23/2009 date of service."

Response Submitted by: Liberty Mutual Insurance, 2875 Browns Bridge Rd., Gainesville, GA 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 23, 2009	Outpatient Hospital Services	\$6,681.48	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated August 19, 2009 and November 10, 2009:

- 16, X936 – CPT or HCPC is required to determine if services are payable.
- 42, U634 – Procedure code not separately payable under Medicare and or Fee Schedule Guidelines.
- 150, Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered.
- 150, X901 – Documentation does not support level of service billed.
- 45, 547 – This bill was reviewed in accordance with your fee for service contract with First Health.
- 42, Z710 – The charge for this procedure exceeds the fee schedule allowance.
- 24, P303 – This service was reviewed in accordance with your contract.
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason codes P303 – “This service was reviewed in accordance with your contract,” and Z547 – “This bill was reviewed in accordance with your contract with your fee for service contract with First Health. The Division requested the respondent to provide a copy of the applicable contract and documentation to support notification to the requestor in accordance with 28 Texas Administrative Code §133.4, pursuant to §133.307(e)(1) which states that “The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request.” The respondent did not submit copies of the requested contract(s); however, they insurance carrier responded on February 21, 2001 stating in part, “The requested information has been sent to Coventry Healthcare for review and response. We have received notification that this provider was non participating at the time of service, therefore, non Network reduction was applicable at the time of service. The bill has been adjusted to pay the additional amount of \$3,016.06 with interest I the amount of \$147.16.” The disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 1400 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code 29881 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0041, which, per OPPS Addendum A, has a payment rate of \$1,943.12. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,165.87. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of \$1,055.46. The non-labor related portion is 40% of the APC rate or \$777.25. The

sum of the labor and non-labor related amounts is \$1,832.71. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$1,832.71. This amount multiplied by 200% yields a MAR of \$3,665.42.

- Per Medicare policy, procedure code 29875 is included in, or mutually exclusive to, another code billed on the same date of service. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with an allowable modifier, review of the submitted documentation finds that the modifier is not supported. Separate payment is not recommended.
 - Procedure code 29999 is an unlisted code. Per Medicare policy documentation is required. Review of the submitted documentation finds that this procedure is not supported. Payment is not recommended.
 - Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J2405 has a status indicator of K, which denotes nonpass-through drugs and biologicals paid under OPPS with separate APC payment. This service is classified under APC 0768, which, per OPPS Addendum A, has a payment rate of \$0.20. This amount multiplied by 60% yields an unadjusted labor-related amount of \$0.12. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of \$0.11. The non-labor related portion is 40% of the APC rate or \$0.08. The sum of the labor and non-labor related amounts is \$0.19. The cost of this service does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total APC payment for this service, including outliers, is \$0.19. This amount multiplied by 200% yields a MAR of \$0.38.
 - Procedure code J2765 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
4. The total recommended payment for the services in dispute is \$3,665.80. This amount less the amount previously paid by the insurance carrier of \$3,666.85 leaves an amount due to the requestor of \$0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August 16, 2012
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.